DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 8/08/15

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445024	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, JOHNSON CITY	3209 BRISTOL HWY JOHNSON CITY, TN 37601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure sprinkler heads were not mixed types. The findings include: Observation and interview on 6/23/15 at 8:47 AM confirmed the sprinkler heads located in the pantry freezer were 1-ordinary and 1-intermediate type temperature rating. (NFPA 13, 5-3.1.5.2) This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 6/23/15.	K 062	Mixed heads had been identified prior to this inspection and the correct heads were on order. The correct sprinkler heads will be installed by East TN Sprinkler. Other areas will be inspected by East TN Sprinkler to ensure no mixed-type heads, and replaced as necessary. East TN Sprinkler will be instructed to check for mixed-type heads during routine maintenance. Maintenance department will check all sprinkler heads for correct installation and report at the next QA meeting.	7/23/2015
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire barrier construction is maintained. (NFPA 101, 8.2.3.2.4.2. and (NFPA 101, 8.3.5.1) The findings include: 1. Observation and interview with the Maintenance Director, on 6/23/2015 at 10:15 AM	K 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

7/17/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 130	Continued From page 1 confirmed numerous improperly sealed penetrations by ductwork, sprinkler piping and other penetrating items in the lightweight concrete 1-hour attic floor separation to the floor below. The penetrations were filled with a rock-like material and no UL listed firestop system was used. 2. Observation and interview with the Maintenance Director, on 6/23/2015 at 12:40 PM confirmed unsealed wiring sleeve above the fire doors to compartment #5 next to the "RCC-3" office. 3. Observation and interview with the Maintenance Director, on 6/23/2015 at 11:15 AM confirmed combustible floor coverings extended through openings at the 3-hour fire doors separating the facility to the independent living side and the Station 4 fire wall. (NFPA80, 1-11.2.3) 4. Observation and interview with the Maintenance Director, on 6/23/2015 at 10:26 AM confirmed the 3-hour fire door by room 201 failed to close to a positive latch. 5. Observation and interview with the Maintenance Director, on 6/23/2015 at 10:26 AM confirmed the Station 2 pantry door failed to close to a positive latch. (NFPA 101, 19.3.2.1 (7). These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 6/23/2015.	K 130	Identified penetrations will be properly sealed. Identified floor coverings will be properly trimmed. Identified doors will be adjusted for positive-latch closure. Pride Fire Protection has identified the penetrations and presented to engineers for proper penetration recipe to correct problem. The maintenance department will inspect fire barriers for proper installation and function during their routine monthly inspections and after any subcontractor work; they will develop a system for formal notification to inform any subcontractor of the necessary fire barrier standards before any work to or around the fire barriers is initiated. All staff will be in-serviced at next staff meeting to immediately notify maintenance department if any door fails closing to a positive latch. The maintenance department will perform routine inspections of fire barriers and report results to the QA committee on a quarterly basis.	7/23/2015